CancerCare Manitoba
ActionCancerManitoba

Referral Information Sheet

Central Referral Office

Referral by Fax: 204-786-0621
Phone Inquiry: 1-844-320-4545

*For a complete Referral Package, please use the Referral Guide for the disease site involved.
Patient Identifiers required on each sheet submitted.

PATIENT INFORMATION LABEL / ADDRESSOGRAPH

Today's Date:

PATIENT INFORMATION

*Required Information to accompany **Referral Letter** or **Consult Request***

Surname: _____
Given Name & Initial: _____
Maiden or Previous Name(s): _____
DOB: DAY / MONTH / YEAR Gender: ☐ M ☐ F
MB Health #: _____
PHIN: _____
Other: _____

Address: _____
_____
City: _____
Postal Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Is English the patient's primary language?
☐ Yes ☐ No
If no, provide patient's primary language:
_____
Need for interpreter? ☐ Yes ☐ No

Does the patient have any special needs?
☐ Wheelchair ☐ Stretcher
☐ Portable Oxygen
☐ Other: _____

Patient Location:
☐ Home
☐ Hospital-Specify Unit: _____
Unit Phone: _____

REFERRAL INFORMATION

Diagnosis: _____
☐ Confirmed ☐ Presumptive

Reason for consultation:
☐ Newly Diagnosed ☐ Second Opinion
☐ Recurrent/Progressive Disease

Is patient aware of diagnosis? ☐ Yes ☐ No
If no, please explain: _____

Referring Physician's Name: _____
Phone: _____ Fax: _____
Surgeon (If not referrer): _____
Family Physician/Nurse Practitioner: _____

Comments:

www.cancercare.mb.ca/referrals - *Use the disease site specific Referral Guide for completeness, missing items may cause delay in triage process*

REFERRAL PACKAGE CHECKLIST:	If result pending, state date and place done:
☐ Referral Letter (with history & physical, co-existing conditions, allergies, previous malignancy)	
☐ All Pathology & Operative Reports	
☐ All Diagnostic Imaging	
☐ All Blood Work	
☐ Other:	